MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-009422

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2420 STATE FILE NUMBER

FILED MAR 6 1963

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS — DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — DOCUMENT

1
2 223
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4 1
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75

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.
Inside Limits Yes # No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St Louis
Inside Limits Yes # No
d. STREET ADDRESS (If outside, give location) 1211 Soulard Street
Reside on Farm Yes No #

3. NAME OF DECEASED (Type or print) First LUCILLE Middle M Last SMITH

4. DATE OF DEATH Month 3 Day 2 Year 63

5. SEX Female

6. COLOR OR RACE White

7. Married Never Married # Widowed Divorced

8. DATE OF BIRTH 3/11/02

9. AGE (last birthday) 60

IF UNDER 1 YEAR Months Days
IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Table Worker

10b. KIND OF BUSINESS OR INDUSTRY Lennox Mfg

11. BIRTHPLACE (City and state or country) St Louis Missouri

12. CITIZEN OF WHAT COUNTRY U S

13a. FATHER'S NAME John Smith

13b. MOTHER'S MAIDEN NAME Elizabeth Trevenicek

14. NAME OF HUSBAND OR WIFE None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of servi

16. SOCIAL SECURITY NO.

17. INFORMANT Address Marie Bujnak 1211 Soulard Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia Bronchial
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 493x

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3 2 63 to 3 2 63 and last saw her him alive on 3 2 63
Death occurred at 11:10 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas L. Ruben M.D.

22b. ADDRESS 1515 LAFAYETTE AVE.

22c. DATE SIGNED 3 2 63

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 3/5/63

23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery

23d. LOCATION (City, town, or county) (State) St Louis County Mo.

24. FUNERAL DIRECTOR ADDRESS Moydell Funeral Home 1926 Allen

25. DATE RECD. BY LOCAL REG. MAR 4 1963

26. REGISTRAR'S SIGNATURE Hal Smith, M.D.

BY AFFIDAVIT OF

Helen E. Taylor 3-14-63
Coroner

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Hadley R. Fuller Jr

Licensed Embalmer No. 495-0

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.